McGill Pain Questionnaire – Short Form

DIRECTIONS: Please read each word below, and decide whether it describes what your pain has felt like over the PAST 4 WEEKS. If a word *does not* describe your pain, circle NO (DOES NOT APPLY), and go on to the next item. If a word *does* describe your pain, then rate how strongly you have felt that sensation (1=Mild, 2=Moderate, 3=Severe). Remember, make these ratings as to how your pain has felt over the PAST 4 WEEKS.

My pain felt like it was . . .		*DOES NOT APPLY*	*MILD*	*MODERATE*	*SEVERE*
1.	THROBBING ……	0	1	2	3
2.	SHOOTING ……	0	1	2	3
3.	STABBING ……	0	1	2	3
4.	SHARP ……	0	1	2	3
5.	CRAMPING ……	0	1	2	3
6.	GNAWING ……	0	1	2	3
7.	HOT – BURNING ……	0	1	2	3
8.	ACHING ……	0	1	2	3
9.	HEAVY ……	0	1	2	3
10.	TENDER ……	0	1	2	3
11.	SPLITTING ……	0	1	2	3
12.	TIRING – EXHAUSTING ……	0	1	2	3
13.	SICKENING ……	0	1	2	3
14.	FEARFUL ……	0	1	2	3
15.	PUNISHING – CRUEL ……	0	1	2	3

Please circle the number which describes your level of pain *right now:*

0	1	2	3	4	5	6	7	8	9	10
NO PAIN					MODERATE PAIN				WORST POSSIBLE PAIN	

Please circle the number which describes your *typical level* of pain:

0	1	2	3	4	5	6	7	8	9	10
NO PAIN					MODERATE PAIN				WORST POSSIBLE PAIN	

Please check the word that best describes your pain right now:

_____ NO PAIN
_____ MILD
_____ DISCOMFORTING
_____ DISTRESSING
_____ HORRIBLE
_____ EXCRUCIATING

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